DEPARTMENT OF SOCIAL & HEALTH SERVICES
HEALTH & RECOVERY SERVICES ADMINISTRATION
January 27, 2006

SeaTac Marriott
3201 S. 176th Street
Seattle, WA 98188

Members Attending

Janet Varon
Barbara Malich
Maria Nardella
Chris Jankowski, OD
Claudia St. Clair
Jerry Yorioka, MD
David Gallaher
Kathy Carson
Blanche Jones
Mark Secord
Eleanor Owen (by conference call)

Members Not Attending

Elyse Chayet
Allena Barnes

HRSA Staff

Doug Porter
Debbie Meyer
Jim Stevenson
Steven Wish
Roger Gantz
MaryAnne Lindeblad
Heidi Robbins Brown
Richard Kellogg
Susan Lucas
Bob Covington
Jeff Thompson

Guests

Paul Dziedzic
Bob Perna

Approval of the Minutes

The minutes for the November 18, 2005 meeting were approved.

Introductions

Doug Porter introduced **Paul Dziedzic** to the advisory committee and stated that Paul would help facilitate the day's meeting. Paul then asked Doug and Janet to make some introductory remarks.

Doug stated that he has found this committee to be a very helpful group and a good sounding board for the past three and a half years. He said he enjoyed meeting each person and that he hoped the day would help committee members be a more helpful group for the Medicaid program. Over the course of the

next year, the committee should rethink its role and move away from its past reactive posture. As a true advisory committee, the group needs to be more proactive – helping inform policy decisions rather than critique actions or programs already in place.

.

Janet Varon: A number of people thought it would be a good idea to have an orientation for the advisory committee. This will also help new members as they come on board. The advisory committee as a whole has been trying to find a more effective way to help the administration. We need to figure out where our focus is. Today's program incorporates some recommendations that the executive committee put together on how the group works and should function – and members need to talk about procedural ways to make this happen.

Paul said the day's agenda would help members identify future areas of focus and explore ways the committee can be more effective and influential in the coming year. One of the big issues is how the committee can be involved in decision making by the administration.

Paul went through the agenda for the day: Orientation; identifying areas of focus, identifying the work in each area of focus, and how does the committee want to operate and how can it organize to be more effective in the future.

Orientation: Doug and **Roger Gantz** led committee members through a basic outline of Medicaid programs in Washington State: Who's covered under Medicaid, where does the money go, how fast are we spending it; HRSA's organization; cost containment efforts, and Medicaid reform proposals.

Doug pointed out that Medicaid covers about one million people in the state of Washington. It is a needs-based program, which means that if you meet the criteria for your household income you are eligible for Medicaid coverage.

In the world of Medicaid programs, there are mandatory obligations to cover certain groups of people. There also are options for coverage that may exceed the federal minimums: These programs cover the medically needy; children in families above 100% FPL; low-income women diagnosed with breast and cervical cancer; health care for employed persons with disabilities; and the medical care services program.

Cost of coverage is split between federal and state dollars. Washington's split is about 50-50 state-federal. Overall, the state's Medicaid program is budgeted for $7.5 billion in the current biennium. (That figure does not include the Medicaid dollars used to pay for mental health treatments or long-term care.)

The $628 million maintenance level growth in the current budget is due to three main factors:

1) Higher costs per person
2) Loss of one-time federal dollars
3) More people covered.

Some clients are more expensive than others. The elderly population is only about 8% of our caseload, but accounts for a much larger share of Medicaid expenditures. Children represent about two-thirds of the total caseload but are much healthier and represent a smaller share of costs. Children's enrollment is

increasing at a rate of about 5 percent more a year; the elderly and disabled populations are also increasing, at about 4 percent a year.

Medicaid has two basic types of delivery systems; managed care and fee for service. Managed care is 58 percent of the Medicaid population, and the fee for service population is 42 percent of the population.

Medical expenditures increased at 10 percent a year between FY98 and FY04. While that rate may be slowing, no one expects it to drop very far.

In 2003 and 2004 state health programs were directed by the Legislature to try to reduce the growth in spending. Those cutbacks included:

- Reducing Basic Health enrollment to 100,000
- Increasing BHP enrollee cost-sharing
- Cutting Medically Indigent program, which helped reimburse hospitals for uncompensated care;
- Increasing eligibility verification by requiring six-month reviews instead of annual checks
- Limiting managed care rate increases
- Eliminating rate increases for other medical providers
- Reducing the adult dental coverage by 25 percent
- Establishing a statewide preferred drug list.

These measures produced savings and helped slow the rate of increase in spending.

Medicaid Reform: In recent years, there has been a growing movement in Congress and in the National Governors Association for more systemic changes that could help manage the Medicaid program more efficiently and contain costs more effectively.

There are four general steps to the Medicaid Reform proposals backed by the NGA and State Medicaid Directors:

1) Streamlining Medicaid – achieve efficiencies without jeopardizing quality of care.
2) Enhancing quality and reducing costs – increasing cost-effectiveness and improving quality of care.
3) Slowing caseload growth – reduce the trend of lower-income workforce enrolling in public health plans
4) Slowing growth of long-term care spending – strengthening private sector resources than can support these costs.

Streamlining Medicaid: Some of the options could include: Creating a new Average Sales Price to better reflect the actual cost of pharmaceuticals; shutting down inappropriate fund transfers; allowing flexibility in the benefit package, cost-sharing and eligibility periods; providing more legislative and program flexibility; integration of services, and client-centered programs.

Slow Caseload Growth: Some proposals include individual health-care tax credits would be a benefit available to all low-income individuals as a premium subsidy paid directly to the health-care provider; employers could receive tax credits by supporting benefits for low-paid workers and their families; state purchasing pools could be organized on a large-scale basis with benefits available to both small businesses and individuals.

Slow Growth of Long-Term Care: Ideas include reverse mortgages, a painless way for many individuals to pay for long-term care even if other assets have been exhausted; tax credits for long-term care insurance can encourage younger people to purchase private coverage – only about 2 percent of the eligible population currently buys long-term care insurance; long-term care partnership repeals the federal ban on backstop coverage, another way to reward those who purchase private insurance and support the private marketplace; integrate "dual eligibles" into Medicare over 10-15 years and move out-of-pocket costs and long-term care out of Medicaid.

Realignment of HRSA

Doug outlined the realignment that brought the Mental Health Division (MHD) and the Division of Alcohol and Drug Abuse (DASA) into HRSA last summer. Those two divisions currently have advisory bodies of their own, and Doug said he would like to see more intercourse between the different groups but that he did not foresee a need to combine the specialized advisory groups in one large body. The committee also heard brief presentations from HRSA division directors present at the meeting. Each director spent a few minutes talking about the functions within their division.

Legal basis of the advisory committee

The federal statutes specify some of the organizations that must serve on the Title XIX Advisory Committee. It also requires staff assistance from the Medicaid agency and financial help for the committee members. Different states have differing types of committees and differing levels of activities. Some states have a robust committee, other states basically have committees that exist on paper but do little in the way of advising the program.

Janet reviewed the advisory committee by-laws with the committee. Washington State currently has 13 members, and needs to add at least two members to bring the committee to the minimum (15) required in the bylaws. In addition, several other members' terms (including the chair) are about to expire.

Possible future focus

Paul asked Doug to frame out three or four issues that he believed to be of importance and that he thought would benefit from advisory committee participation:

1) The first issue on Doug's list was health disparities among ethnic and minority populations. Some specific examples include the fact that Latinos have diabetes out of proportion to the general population; African American women have a significantly higher risk of late-stage breast cancer diagnoses when compared to the general population; Native Americans have problem with alcoholism out of proportion to the general population. Doug said it is part of Medicaid's responsibility to look at

this kind of issue and to help devise strategies, interventions and solutions that the health-care system overall can employ. We need to start engaging with each other because no one group has the answers.

Doug said the other issues are allcrossover topics:

2) Care management needs to move beyond the Temporary Assistance to Needy Families (TANF) population into other areas of managed care. In the 1990s, preceding Doug's appointment, there was a push to move the Medicaid SSI population into managed care, but it wasn't successful. Doug asked, how can we develop strategies that better focus programs on what clients need -- not necessarily by diagnosis.

3) The next issue is improving health-care utilization. We need to educate our clients how to use the system to their advantage. It is difficult for people to navigate the current health care system. We need to better identify resources and work with providers and consumers on strategies that let our clients utilize the medical system.

4) Prevention is a big piece of the Governor's Health Initiative. Many people think that prevention efforts are something that only the Department of Health needs to worry about. But prevention should be a theme in all health care. How can it be woven into the Medicaid system?

Doug noted that all of these policy initiatives would have to be supported by the HRSA budget.

Other areas of committee involvement

POG: Doug said he has normally just kept the committee informed about the Priorities of Government process in retrospect. However, HRSA executives and policy analysts and planners have done some preliminary work for the 2005-07 biennium. Doug said he would like to see the committee participate in the prioritization of the strategies earlier in this POG process.

TOWN HALLS: Doug would like to see the administration sponsor some new town hall meetings, providing more client and public feedback. He said he also would like to see the committee hold meetings in other areas than SeaTac -- and open up a portion of the meeting to hear about issues that are happening in that particular area.

Kathy Carson asked Doug whether this kind of meeting has helped in the past. Doug felt it was very informative to hear from clients and providers about what they were experiencing.

Committee comments

Paul asked the committee members how they felt about Doug's list of policy issues. Did members agree with his list, or were there other issues that are missing and that they would like to propose?

Mark Secord – He suggested that safety be included in issues 2) and 3). He said six principles developed by the Institutes of Medicine (IOM) should be included in patient directive care. Paul asked Mark where he thought the safety issue should be included. Mark was not sure, but Doug said he thought it could be incorporated in the care management issue.

Maria Nardella – Maria said she hoped that the health disparities topic would also address geographic differences in health care.

Kathy Carson – She'd like to see more attention on the ability to access services. Doug said he felt this would be part of the improving health care utilization. We should not only be educating clients about what they can do for themselves but also teaching them how they can access appropriate care.

Janet – She felt that access could also be included in the health disparities initiative. She believes that access is the way that this plays out. The main thing the group needs to focus on is: How can we improve the access? Doug stated that in the studies he's read, it hasn't necessarily been a matter of not being able to access the care but it's following the course of treatment established for the patient.

Kathy Carson – Doug's four topics are key issues in public health strategies as well.

Barb Malich – One of the things that she would categorize in health disparities is the inter-relatedness between behavioral health and physical health. When HRSA did their ER study, the most frequent users of the ER had the highest behavioral health and/or substance abuse needs. The notion of integrating parts of the silo-ed system cuts across all the issues.

Doug also introduced **Richard Kellogg,** HRSA's new Mental Health Division Director. He and Richard noted that the public mental health system faces many current challenges, including a recent court decision that could change the state's commitment to capacity at Western and Eastern state hospitals.. **MaryAnne Lindeblad,** who served as Interim Director of MHD, has helped Richard come up to speed. They pointed out that one of the challenges is for the delivery of services to focus on what the client needs, but that if we can do it, we have a better chance of meeting customers' needs. Doug and Richard noted that the state is lucky to be among the handful of states awarded a transformation grant to review and revamp the mental health delivery system. The committee should have interaction with the transformation grant.

Dr. Yorioka – He said he feels that premature mortality was not addressed in any of the policy areas Doug outlines. However, Doug said he felt it could be covered under health disparities.

Barb asked Doug how long he thought the committee would be involved with an issue like that. Doug said he felt the areas he outlined would be current issues for at least the next couple of years. He asked committee members whether they thought the list was too much for the committee to take on. Do we need to pare it down and focus on fewer concerns?

Paul suggested members needed to consider the following questions for each area of focus:

- Is it clear what it addresses?
- How/when is HRSA thinking it wants to tackle/work on this?
- How could the advisory committee operate/organize to be an effective and influential partner on this?

Health Disparities Initiative

Dr. Nancy Anderson was identified as the staff person who has been involved in health disparities. She has prepared two pages worth of ideas/strategic considerations/areas of further exploration, and Doug suggested it would be a good first cut for the committee.

Kathy Carson noted that DOH and King County Public Health have done a lot of data analysis on this subject matter that might be useful to this committee. Kathy said she was interested in seeing Dr. Anderson's list.

Committee members asked what they would be looking for -- trying to get reports, looking at ways to improve client education, or other activities. Doug stated he felt there was a lot of information but then we need to figure out what to do with the data?

Paul asked whether the committee would be interested in having a small group review the data and come back to the committee with information. Or would members prefer to start the activity with a presentation by Dr. Anderson, sharing what she knows about the issue?

Committee members' consensus was to ask Dr. Anderson to provide a status report on the current state initiative in health disparities and to provide background documents for the committee to review, including suggestions about what the Medicaid program can do. Dr. Yorioka and **Bob Perna** agreed to work with Dr. Anderson in advance of a special committee meeting on February 24 to specifically talk about health disparities.

Members also agreed that a subcommittee could assess some of the information that is available and be responsible for suggesting strategies to the advisory committee.

Did the committee want to look at the big picture or should it be thinking in terms ofone or two strategies? There was no immediate consensus, but members agreed that coordinating with roles of other organizations would be good. Committee members noted that there appeared to be a lot of great ideas in the Legislature's interim disparity report and maybe it would be a good idea to pull the ideas into one list.

Integrative Care

This initiative centers on the minority of clients who are the most costly of our clients. We have taken the disease specific approach with limited success, Doug noted, adding that we did not see the savings that we were hoping for. What we did learn was that we can focus on the client and improve outcomes, but you can't do it by ignoring providers. Doug said HRSA is are now at the point of putting out its next RFP in care management and needs to be making decisions quickly.

Questions the administration faces include how we can take mental health, oral health, and substance abuse issues into account? In addition, colleagues in Aging and Disability Services Administration are working on chronic care management, which overlaps with HRSA's pilots. The good news, Doug said, is that this doesn't have to fit into the POG process or budget process. Whatever we do can happen throughout the year.

Comprehensive diabetes management system is a computer program that DOH has devised to help inform care decisions. Dr. Yorioka said he has been using that tool and would recommend it to other parts of health care.

On the issue of health-care technology, Doug noted that HRSA has tried to get Eastern State Hospital to hook up with technology on electronic records. The Health Care Authority has some dollars that will be made available to small practices that would benefit from technology.

Bob offered a few comments -What interventions have we done? Where have we saved money? What's been useful so far? How do we share what seems to be working best and then mobilize it throughout the community. He said the committee also could help coordinate best practices – perhaps adding to a repository of best practices, or successful outcomes and how they were achieved. Doug said he was hoping to share an inventory that includes more detailed descriptions of all the things that HRSA is doing in an attempt to manage care.

Barb asked if HRSA looks at this data just on a fiscal basis or if it considers outcomes of the program as well. Doug stated that he looks at both, noting that HRSA has started an integration program in Snohomish County that features a number of activities. But HRSA can't just keep adding more and more to its pilots without solid evaluation of what the costs and benefits are. At some point, the state has to determine what's actually working.

Kathy said this was an area she was interested in and wants to help. She also would like to hear more about what we've learned from the various initiatives that we've tried.

Paul led a discussion about integrative care questions, and committee members agreed that it proably was premature to make decisions about its approach. They concluded a future discussion would be needed to decide whether to have a few committee members form a sub-group or have HRSA first bring more information back to the committee.

Improving Health Care Use

This discussion was a byproduct of the first two issues. Committee members agreed there has to be a patient focus to improved health care. Doug noted that we have learned you can improve outcomes by better engaging the clients. HRSA still needs to figure out the mechanics of it, and is only on the ground floor. A few projects have provided some information. For example, the Access to Baby and Child Dentistry (ABCD) program has clearly helped make more dental services available to low-income children.

Members agreed that a sub-committee would work closely with HRSA staff to assess where HRSA is now, what potential opportunities/strategies make most sense to pursue – and then bring those answers back to the committee for further refinement and recommendations. Members expressing interest in serving on the subcommittee included: **Claudia St. Clair, Barb Malich, David Gallaher and Chris Jankowski.**

Health Promotion & Disease Prevention

Doug said HRSA representatives have been pretty pleased with ourselves regarding the incentives for managed care plans around immunizations, well child care, etc. But he noted that DOH Secretary Mary Selecky challenged DSHS to take the next step in the wake of the Governor's health care initatives. As a result, HRSA is starting to partner with HCA and DOH to talk about health promotion.

Some committee members said they did not feel a need to be involved in those discussions, but that it would be good to stay abreast of prevention issues. They asked if HRSA could provided a status report at the summer meeting. There was a consensus that the advisory committee could consider and/or identify future areas of opportunities for prevention initiatives in the future.

POG Process

Doug reiterated his vision of using the committee as a resource on areas identified in the POG process. HRSA would bring information to the advisory committee at the appropriate times to keep them informed on key decisions. He noted that HRSA has already started the process for the next biennium's budget but that he and other POG staff could share the progress so far. That would be a beginning point for the committee to see how and if it would become more involved. Doug said this briefing could be set for either the February or March meetings – or even in May.

Town Hall Meetings

These meetings would have to be funded out of our current administrative budget, and many of the committee members thought these meetings would be beneficial. Members said the committee and HRSA needs to think strategically about when and where they would be held – what issues need focus at them, and what we want them to accomplish. There was conditional support for getting involved – provided the topics to be discussed are timely. Members noted town meeting swill take a lot of planning.

Executive Committee recommendations

Janet outlined several recommendations from the three-person Executive Committee:

The Executive Committee wants to be responsive to issues that arise at the last minute, and a structure of subcommittees could be useful in maintaining continuing between meetings.

The committee does need to increase its membership.

The executive committee also wants to reconsider the time spent on community reports. Within the next four months, the advisory committee should address the role of community reports and other ways committee members use to gather information, concerns, complaints and positive feedback.

The committee needs more current contact with discussions and decisions made by HRSA's Executive Committee. The committee also would like supporting materials sent out at least one or two weeks in advance of each meeting.

Barb, also an Executive Committee members, said she feels that the Advisory Committee needs to be wary of the temptation to act as an oversight body. She said the committee should see itself as informational and helpful, particularly when it comes to providing feedback or offering advice that will help HRSA make better decisions.

Final thoughts, summary

Paul suggested some clarifications to the executive committee recommendations that he heard.

Recruitment – Doug suggested that Deputy HRSA Assistant Secretary Heidi Robbins-Brown could take the lead in recruiting additional advisory committee members.

Elections -- New leadership is scheduled in March

Organizing -- Clarify the role of the advisory committee as an organizing role.

Focus areas – Look to ad-hoc subcommittees built around current issues rather than standing committees.